No. 5874 RIN P. 7 05/26/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING A COMPLETED 445469 B. WING 05/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 301 WATAUGA AVE IVY HALL NURSING HOME ELIZABETHTON, TN 37643 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY) K 021 NFPA 101 LIFE SAFETY CODE STANDARD K 021 SS=E Doors in an exit passageway, stairway enclosure, Corrective Actions for Targeted horizontal exit, smoke barrier or hazardous area Residents enclosure are self-closing and kept in the closed position, unless held open by as release device On 5-26-16, the Maintenance Director complying with 7.2.1.8.2 that automatically closes contacted Trimble door to replace the 3rd all such doors throughout the smoke floor and 1st floor center stairwell doors compartment or entire facility upon activation of: to a labeled fire door. The installation will (a) The required manual fire alarm system and be complete by 7-8-16. (b) Local smoke detectors designed to detect smoke passing through the opening or a required Identification of Other Residents with smoke detection system and Potential to be Affected (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, On 5-26-16, the Maintenance Director Inspected facility fire doors and found no 7.2.1.8.2 other areas affected. Door assemblies in vertical openings are of an approved type with appropriate fire protection Systematic Changes rating, 8,2,3,2,3,1 Measures to assure compliance include a quarterly audit of fire doors by the Boiler rooms, heater rooms, and mechanical Maintenance Director to ensure that equipment rooms doors are kept closed. they have proper labeling and that labels This STANDARD is not met as evidenced by: have not been painted over. Based on observation, the facility failed to provide labeled fire doors in the stairwells. Monitoring The findings include: Results of these audits will be reported quarterly by the Maintenance Director Observation on 5/25/16 at 10:15 AM and 10:45 to the Quality Assurance Performance AM revealed doors on the 3rd floor and 1st floor Improvement Committee for Review and protecting the center stairwell are not labeled fire Recommendations. The Assistant doors. Administrator and Maintenance Director will follow up on recommendations from These findings were verified by the maintenance QAPI Committee to tha assirre director and acknowledged by the administrator compliance. during the exit conference on 5/25/16. Continue LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPASSENTATIVE'S SIGNATURE TITLE (X6) DATE

Am deficiency/statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING			FORM APPROVED MB NO. 0938-0291 (X3) DATE SURVEY COMPLETED	
445469			ŀ	8. WING			05/25/2016	
NAME OF PROVIDER OR SUPPLIER IVY HALL NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 301 WATAUGA AVE ELIZABETHTON, TN 37643				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENYIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ar	(X6) COMPLETION DATE	
K 021 SS=E	Continued	" ") "	Ко	21	Manitoring (Continued)			
	g)				The Quality Assurance Performal Improvement (QAPI) Committee consoft the Executive Director, Med Director, Director of Nursing, A Director of Nursing, Director of Nursing, Director, Med Records Coordinator, Social Servi Director, Activities Director, Busin Office Manager, Human Resoun Manager, Maintenance Director a Rehab Manager and MDS Coordinator.	sists lical ust. ger, lical ces ess ces and	7/8/15	

Event ID: M7N011

Facility ID: TN1008

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TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safepoints provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days. Solicowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Jun. 8.2016 3:31PM No. 5874 PRINCED: 05/26/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A BUILDING 01 - MAIN BUILDING A 445469 B. WING 05/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CRY, STATE, ZIP CODE 801 WATAUGA AVE IVY HALL NURSING HOME ELIZABETHTON, TN 37643 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE, DEFICIENCY) K 029 Continued K 029 Monitoring (Continued) Assistant Administrator and Maintenance Oirector will follow up on recommendations from the QAPI Committee to assure compliance. The Quality Assurance Performance improvement (QAPI) Committee consists of the Executive Director, Medical 3.5 Director, Director of Nursing, Asst. Director Nursing, Dietery Мападег, Housekeeping Supervisor. Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator. 7/8/16

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Event ID: M7NO21

Facility ID: TN1003

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Jun. 8. 2016. 3:31PM FRANCIMENT OF DEALTH AND HUMAN SERVICES No. 5874PRIIP. 1105/26/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 08 - 1994 ADDITION COMPLETED 445469 B. WING 05/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 301 WATAUGA AVE IVY HALL NURSING HOME ELIZABETHTON, TN 37643 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY). K 130 NFPA 101 MISCELLANEOUS K 130 Corrective Actions for Targeted SS=D OTHER LSC DEFICIENCY NOT ON 2786 Residents This STANDARD is not met as evidenced by: On 5-26-16, the Maintenance Director Based on observation, the facility falled to maintain fire raied doors. contacted Trimble Door Company to repair the latch of the cross corridor fire The findings include: doors by room 407. Trimble will Install a UL rated fire stop pin to secure the Observation on 5/25/16 at 1:04 PM revealed the lower portion of the door during a fire. cross corridor fire doors by room 407, the lower The repair will be completed by 7-8-16. latch was not working and protruding into the floor strike. Identification of Other Residents with Potential to be Affected This finding was verified by the maintenance director and acknowledged by the administrator On 5-26-16, the Maintenance Director during the exit conference. NFPA 101 2000 Edition - 19.7.6 - 4.6.12 - NFPA inspected facility cross corridor fire 80 2-4.1.4*, 2-5.2 doors latches for the proper operation and found they were working as designed, Systematic Changes Measures to assure compliance include a quarterly audit of cross corridor fire doors by the Maintenance Director to ensure that latching hardware is operating correctly and compliance with NFPA 101 and NFPA 80. LABORATORY DIRECTOR'S SENTATIVE'S AGNATURE (X8) DATE HDMINISTRATER

Any deficiency statement ending with an asterisk (*) detrotes a deficiency which the Institution may be excused from correcting providing it is determined that office safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days. It delicates the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER IVY HALL NURSING HOME SUMMARY STATEMENT OF DEPOLENCIES (EACH DEPICENCY MUST REPRECIBED BY PILL (REGULATORY OR 150 DENTIFYING INFORMATION) K 130 Continued	STATEMENT OF DEPICIENCIES (X1) PROVIDER		OX11 PROVIDERISUPPLIERICUA					
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Results of these audits will be reported quarterly by the Maintenance Director to the Quality Assurance Performance Improvement Committee for Review and Recommendations. The Assistant Administrator and Maintenance Director will follow up on recommendations from the CAPI Committee to assure compliance. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Assr. Director of Nursing, Dieterly Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Sushass Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator. 7/8/16	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FILL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	ULDBE	COME/TELION (X8)	
M CMS-2567(02-99) Previous Versions Obsolete Event ID: M7NO21 Facility ID: TN1003 If continuation shoot Bases 3 of 3	\$\$=D				Results of these audits will be quarterly by the Maintenance D the Quality Assurance Performers of the Quality Assurance Performent Committee for Recommendations. The Administrator and Maintenance will follow up on recommendation the QAPI Committee to compliance, The Quality Asperformance Improvement Committee consists of the Experiment Committee consists of the Experiment Manager, Housel Supervisor, Medical Prector of Indicatory Manager, Housel Supervisor, Medical Fooddinator, Social Services Descriptions and Maintenance Director and Maintenance Director and Manager and MDS Coordinator.	irector to formance view and Assistant Director ons from assure essurance (QAPI) escutive esctor of Nursing, keeping Records irector, Office anager,	7/8/16	